Handling Medical Error: Lessons to be learned from the US?

Medical error is a leading cause of death in Western nations.¹ To address this problem, there have been recent public policy and legal reforms in the UK, including a statutory duty of candour and emphasis on institutional support and responsibility.² These aim to engender a culture of openness and transparency in order to better prevent, address and learn from medical errors. However, there have been limited concurrent educational or institutional changes to support these statutory and professional obligations. Current practices around institutional handling of medical error continues to fall short of these professed policy and legal standards, as was borne out in the case of Dr. Hadiza Bawa-Garba.³ This case reignited debate around medical errors in the UK and how they ought to be handled and the medical community expressed outrage and fear over the decisions of the Court and General Medical Council.³ It highlighted the tension between the legal tendency to pinpoint blame and the professed aim of the medical community to acknowledge collective responsibility. In particular, many called for new ways to consider how institutions can better support individuals involved in instances of medical error.

Medical practice in the US has gained a reputation for its litigious culture and many individual hospitals are taking steps to avoid medical errors in order to reduce litigation and improve patient care.⁴ As part of the Masters of Bioethics programme at the Center for Bioethics, Harvard Medical School I interned with the Ethics Committee at Beth Israel Deaconess Medical Center. As part of this I assisted in ethics consultations requested by patients and clinicians and I took particular interest in their proactive approach to handling medical errors. This report considers some of the steps taken by BIDMC to address and reduce “preventable harm” and how they might be applicable to UK medical practice.

One method by which BIDMC aims to promote collective responsibility around medical error is by publishing quarterly reports of “Preventable Harm” online.⁵ On their publicly available website, the hospital lists the number of reported errors across many contexts, including surgical site infections, falls resulting in injury and disrespectful communication. This allows for ready identification of common errors, which has led to review and improvement in areas such as infection control. It aims to destigmatise error and share responsibility for improving practice between clinicians and management. By encouraging open dialogue around errors, the hospital aims to demonstrate to patients and families that they are actively identifying important contexts
where mistakes commonly occur and proactively addressing them. This approach to transparency is relatively unique among Massachusetts hospitals and I could find no record of UK Health Boards doing anything similar. Given that data around numbers of incidents of medical error are commonly recorded by hospital management, it would be feasible to create comparable documentation in the UK—whether available online to the public, to clinicians only, or available upon request. Tracking such numbers might provide the institutions with a certain accountability to ensure that areas of common mistakes are acknowledged and could identify specific areas that require additional support.

Secondly, BIDMC (along with other Massachusetts hospitals) have introduced a Communication, Apology and Resolution (or “CARe”) initiative. Clinical staff are provided with training to encourage timely communication with patients and families.

The “CARe” initiative is offered as means of encouraging collaboration between involved parties to prevent future errors. Meetings between parties following difficult events can provide valuable time for personal and team reflections on the surrounding circumstances and emotions and what might be done in future to improve practice. Decisions regarding whether to pursue litigation are complex and multifactorial but the provision of an alternative, non-adversarial but official pathway for dealing with mistakes is thought to reduce rates of legal action. Data tracking practice since 2001 at the University of Michigan has demonstrated that such a programme as led to a reduction in the number of patient injuries claims, system improvements following investigation of claims, shorter time to claim resolution, and significantly decreased costs for both the claimants and the hospital involved.

Given that the cost of legal claims is known to be rising around the UK, such a system would not only encourage valuable (and confidential) individual reflection but also serve as a means of allowing funds to be spent on improving care rather than costly compensation.

Thirdly, BIDMC Ethics Committee provide consultations at any point of patients’ journeys. They can provide support, guidance and mediation around complex decisions, reducing harms like disrespectful communication. They also offer discussions and debriefs with patients, families, and clinicians after difficult events to ensure all perspectives are considered to improve practice. Ethics committees who provide such contemporaneous advice, actively meet with all stakeholders, and provide care-guiding advice remain rare in the UK; in the US, almost every hospital now has some form of committee providing such consultations.

My experience demonstrated the role of committee members (with appropriate training in communication) being involved early in discussions with the medical teams after an error to
advise on the most suitable methods and circumstances to discuss the errors with patient and family. They often worked in conjunction with the hospital legal team to counsel on how to broach the subject with honesty and integrity, while assuaging clinicians’ commonly-held fears around litigation.

In conclusion, medical error is a complex but important issue that must be acknowledged and addressed. My experience with BIDMC Ethics Committee has demonstrated some ways in which mistakes can be identified, tackled and prevented. Transparent record-keeping of numbers and patterns of incidents, explicit programmes to encourage communication and collaboration around medical error, and ethics committees to provide guidance and mediation are all examples of some methods that could be used to improve practice.

REFERENCES


Sarah Kelly, a medical student at University of Edinburgh received an IME Scholarship for her Master of Bioethics intercalated degree at Harvard University, August 2017. Read the report of her project below:


REFERENCES

Sarah Kelly, a medical student at University of Edinburgh received an IME Scholarship for her Master of Bioethics intercalated degree at Harvard University, August 2017. Read the report of her project below:

Written by Phil Greenwood
Wednesday, 14 August 2019 12:30 - Last Updated Thursday, 15 August 2019 09:32


